Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N049002	A. BUILDING: _____ B. WING _____	C 05/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVILAND CARE CENTER LLC	200 MAIN HAVILAND, KS 67059

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citation represents the findings of the complaint survey for complaints #64821 and #65385.	S 000		
S 976 SS=F	26-40-302 (b)(c) P E - Door monotoring system (B) The electrical monitoring system on each door shall remain activated until manually reset by nursing facility staff. (C) The electrical monitoring system on a door may be disabled during daylight hours if nursing facility staff has continuous visual control of the door. This REQUIREMENT is not met as evidenced by: The facility census totaled 48 residents. The building had a total of 6 doors to the outside and accessible to residents. Based on observation, interview, and record review, the facility failed to monitor by electrical alarm or visual control 3 of the 6 exit doors. (Front door, Soiled utility exit door, and courtyard door) Findings Included: - During an interview on 4-25-13 at 10:20 a.m. during a tour of the facility Administrative staff A explained how and when all of the exit doors were locked and/or alarmed. Administrative staff A reported all the exit doors were connected to the wander guard system. The north and south hall doors were always alarmed and locked to where no one could get in, and had a wander guard alarm connected to them. Surveyor clarified that they were not locked in the sense that no one could get out, just no one could get in. The soiled utility room on north hall had an outside	S 976		

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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door to it that was locked and alarmed at 3 p.m. to 5:30 a.m. It did not alarm during the day so the residents could take their trash to the dumpster if they wanted. The door had a turn lock on the handle, which was activated during the hours the alarm was on so, "if they wanted to unlock it they could but the alarm would sound." The hall door to the soiled utility room was not locked and observations throughout the survey revealed the door was unlocked each time checked. The front door was unlocked and unalarmed from 5 a.m. to 9 p.m. at which time it was locked and alarmed and also had a wander guard on it. The kitchen had an outside exit door that staff locked and alarmed at 7 p.m. and was unalarmed at 5 a.m. when staff came in. When staff was not in the kitchen, the door to the kitchen was locked. The smoking area door off the dining room was alarmed at 10:30 p.m. until 5 a.m. at which time it was unlocked and the alarm turned off.

Review of the Door Alarm Schedule revealed north and south doors were to be locked at all times, (could not come in from the outside) doors could be opened at any time but alarmed when opened. It also originally showed the front door to be alarmed and locked after the last smoke break each evening but it was crossed out and changed to 9 pm.

Review of the Alarm check log dated the month of April 2013 revealed staff checked each of the exit doors for proper working of the wander guard and regular alarms, every shift.

An observation on 4-25-13 at 12:54 p.m. revealed no staff at the front desk visually monitoring the exit doors. A staff person sat at the back table in the dining room looking down and writing in a notebook. The only door that would have been in

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his/her view were the dining room and front exit doors. At 1:05 p.m. licensed nurse B sat at the nurse's desk charting and at 1:08 p.m., staff B left the desk and went down the south hall and came back at 1:10 pm. From 1:10 to 1:25 p.m. staff B was in the med room with his/her back to the front door and not in view of the camera monitor or the door. Staff B would not have been able to visualize any of the doors or the surveillance monitor during that time. During this same time frame, Administrative staff C was in his/her office that did not have a monitor or direct view of the front door. Observation during this time period revealed 5 different residents go in and out of the front door without signing in or out.

During an interview on 4-25-13 at 3:46 p.m. direct care staff D reported that every resident was checked visually at least every 2 hours. He/she reported if the nurse was not in the nurse's station, staff D tried to stay there to keep an eye on the front door.

During an interview on 4-19-13 at 2:16 p.m. direct care staff E reported the residents earned off ground privileges according to how they functioned and participated within the facility. Residents were supposed to sign out when and where they went and put down the time they left, and the time they returned. Staff did 2 hours checks on every resident and if someone was not here for that 2 hour check then a search was started.

During an interview on 4-29-13 at 3:12 p.m. direct care staff F reported there was a list of residents at the nurses ' station that showed who could and couldn't go off grounds and for how long. The list also included residents who could not go outside without supervision. Staff F reported

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residents who go out the front door were supposed to sign out if they were going for a walk or going to sit on the porch. The smokers did not sign in or out when they went to the courtyard because staff was usually out there when residents went on their smoke break. Residents who had off grounds privileges could go to the store by themselves or could go where they wanted but had to sign where they planned to go.

During an interview on 4-29-13 at 4:21 p.m. direct care staff H reported there was a list of residents who had different privileges and some who had bands on that could not go outside or an alarm would sound. When asked how staff knew when someone who could go outside on the premises stayed on the premises or left staff H stated he/she "assumed they were on the honor system" .

During an interview on 4-29-13 at 4:23 p.m. nursing staff J reported residents were supposed to sign, date, and time when they went out and what they were doing. Staff J said residents who were just going to the porch would sign out as well. The facility got cameras last year and they help a lot in monitoring where residents are and staff could see every exit door of the facility. Staff J reported residents who had on ground privileges had to sign out that they had gone outside and they could not leave the grounds. When asked how staff knew who was outside, based on observations of residents that went outside without signing out, no staff in the nurse's station to watch the monitor or in view of the door. Staff J confirmed a resident could go outside or off the grounds without staff knowing they left the building. Staff would notice them not there, either at a meal when seating residents or during a 2 hour check. "There is a lot of visualization

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that has to happen here." When there was one nurse and one or two aides, staff could not always be in the nurse's station to watch the door.

During an interview on 4-29-13 at 4:49 p.m. administrative nursing staff G reported residents were supposed to sign in and out when they went out the front door even when they went to sit on the front porch. When asked specifically about monitoring the unalarmed front door he/she reported there was a surveillance camera at each exit door, staff was to be where they could see the front door, and staff did the 2 hour checks. When explained there had been observations of residents going out the front door without staff aware, staff G reported the facility would not necessarily know they were out of the facility unless someone saw them or if the resident was not found on 2 hour checks, meal time, or break times. Staff G reported that unless a resident signed out the staff might not necessarily know a resident left the building.

During an interview on 4-29-13 at 5:02 p.m. Administrative nursing staff I reported if someone went to sit on the porch he/she do not have to sign out. When asked how they knew a resident who was only supposed to be on the porch or just on the facility grounds didn ' t go off the grounds, Staff I reported that was why staff did checks because they didn't know.

During an interview on 4-29-13 at 5:18 p.m. Administrative staff C reported that typically staff could view residents go in and out the front door and could view residents walking around on the grounds. Most residents had patterned behaviors and staff kind of knew when a resident was going to be sitting on the porch or sneaking around the

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S 976	Continued From page 5 corner to smoke a cigarette. Surveyor requested a policy regarding the alarming and monitoring of the exit doors on 5-1-13 and the facility failed to provide one as of 5-2-13. The facility failed to ensure that 3 of 6 outside exit doors were electronically monitored or under visual control to ensure residents did not exit the facility without staff awareness.	S 976		